OFFICIAL RESPONSES TO VENDOR QUESTIONS
RFP-2021-DBH-12-RESID
February 19, 2021

No.	Question	Answer
1.	**Section 2.1.2 Bed needs for the target population** Can beds be fluid? For example if we have 14 beds total, can sometimes 4 beds be used for one level and 10 beds be used for another level?	See Addendum #6, and revised Appendix J. Additionally, if beds are licensed but shared across levels of care/programs, then a Proposer must clearly explain that in the revised Appendix D- Technical Proposal Response Template. Sharing beds across levels of care/programs may be allowable in specific circumstances, depending on how the programs are operationalized and the licensing requirements.
2.	**Section 2.2.3.12 Education** Given the rules around for classroom placement due to age restrictions, physical space and approved program designation according to Department of Education (DOE) and how these program distinctions will work in connection to approved levels of care and approved beds through the contracts. a) Will the DOE program distinctions change to be aligned with this change? b) If not, how will this be addressed through the RFP?	a) and b) See Appendix H, Level of Care Framework, which Levels 2, 3, 4 are aligned with the existing New Hampshire Administrative Rules He-C 6350. This depends on how you apply for your specific program and the level of care you are proposing and if the programs continue to align with your DOE approved educational program.
3.	**Section 2.2.3.13 Training** a) Is the RENEW Training something encouraged or required for Level 1 staff? b) Would RENEW be considered a strength to have staff trained in it? c) And I know it is a separate service in some agencies with a separate pay scale rather than bundled in with room and board-would that apply for us too?	a) There are no specific models recommended for Level of Care 1. b) The Vendor would need to determine that Renew is a strength to their program. c) Vendors need to submit a cost proposal, which aligns with their technical proposal. This would be included in the per diem rate.
4.	**Section 2.2.3.14 Transportation** Will the CME be responsible for transportation, if needed, to and from the Qualitied Residential Treatment Program (QRTP) on the day of admission?	The residential treatment vendor will need to coordinate with family and team members to provide the necessary services.

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5.	**Section 2.2.3.15 Aftercare and Section 3.4.2 Cost proposal scoring components.** a) How does the State of New Hampshire envision these 6 months of aftercare as required by the Families First Act? b) Will a residential treatment program be reimbursed for such aftercare? c) At what rate will residential treatment programs be reimbursed for said aftercare? d) Will the clinicians working in this 6-month aftercare count in the ratio that the State is asking to maintain between clinical staff and children? e) If yes to letter d) above, how can we plan to hire employees if we don't know how many children we will have in this program and how much the state will reimburse us for this service?	a) See Section 2.2.3.2 and Section 2.2.15. Vendors are required to meet the requirement of the Families First Act to provide up to 6 months of aftercare by providing at a minimum the following activities of aftercare: consultation, virtual attendance meetings, phone calls, etc). b) See answer to #17. c) See answer to #17. The Department will calculate residential treatment rates based on RFP Section 4.2 per diem rate and in accordance with the rate setting form. d) Vendors should take these cases and the workload into consideration when determining their ratio for clinical staff in your proposal response. The proposal should include what would be a reasonable ratio for after care cases. e) The Vendor is asked to approximate the number of proposed beds and should use that number to determine how many employees they should hire.
6.	**Section 2.2.3.2 Coordination with the Care Management Entity (CME) and the Comprehensive Assessment for Treatment (CAT) Provider** Will the beds being referred by parent/guardians, through the Care Management Entity (CME) or Transitional Residential Enhanced Care Coordination (TR-ECC) count as a certified bed through this contracted RFP process?	Yes. The beds being referred for children paid through Medicaid fall under this contract.
7.	**Section 2.2.3.3 Admissions and Discharges** Can you define "staffing concerns?"	See Addendum #6.
8.	**Section 2.2.3.3 Admissions and Discharges** When will the standard admission forms be ready?	See Addendum #6. The Addendum corrected the sentence to read "referral form" and not "admission form."
9.	**Section 2.2.3.3 Admission and Discharges** When will the standardized referral and admission forms be ready?	See answer to #8.
10.	**Section 2.2.3.3 Admission and Discharges** How does the Department envision cases where youth need emergency treatment episodes before a CAT is completed?	See Addendum #6.

No.	Question	Answer
11.	**Section 2.2.3.3 Admissions and Discharges** Will the agencies be included in developing the admission form?	No. See answer #8.
12.	**Section 2.2.3.3 Admissions and Discharges** a) If a Vendor has multiple sites offering the same services, is there flexibility to place children within those sites based on internal resources and best fit for the child and their family? For example, a child who would be discharged to a smaller, rural community school might do better in a similar environment within the Vendor's system of care. b) Could a vendor make that determination or would the Department control the decision?	a) If a Vendor has multiple sites under one program, then it is at the discretion of the program and the team to have the youth admitted or transferred between locations. b) Families First requires for every new residential treatment episode, a Comprehensive Assessment for Treatment (CAT) or confirmation must be conducted within 30 days. Ideally, if it is a planned transition for the child the CAT or confirmation should occur prior to the transition.
13.	**Section 2.2.3.3 Admissions and Discharges** In order to provide the residential, clinical and educational services the individual and their family require will the referral documents provide the range of information needed including: • Family history/summary/chronological history of agency contacts. • Psychological hospitalization and other prior residential placement discharge reports • Reports from other programs with which the child and/or the parents may have been involved. • For Students receiving Special Education Services, a current Individual Education Plan and all evaluations that support the student's special education eligibility within the last 3-year cycle. • Functional Behavior Assessment and Behavior Information Plan. • Critical Incident Reports from school and prior residential service providers. • A medical history including evaluations from all specialists providing medical services, immunization records, complete physical report and medical insurance	See Answer to #8.

No.	Question	Answer
	information. • If applicable, Case Plan, Youth Information Sheet, Court and probation records.	
14.	**Section 2.2.3.3 Admissions and Discharges** Will the CME assist with guardian signatures of Admission forms e.g. Permission to provide treatment, Physician orders to administer medications prescribed at the time of admission, Authorization to exchange personal health information (PHI) etc.?	If the CME is already involved with the children's case, then the CME will assist and follow HIPPA regulations. If the CME is not already involved, then the residential treatment vendor will be responsible to get the necessary signatures.
15.	**Section 2.2.3.3 Admissions and Discharges** Will the CME obtain approval/initiate the Best Interest Meeting for educational placement at the vendor's school prior to making the referral?	Procedures and processes to define the roles and responsibilities continue to be worked on with the understanding that the CME's intent is to support clients between the CME and the residential treatment vendors.
16.	**Section 3.4.2 Cost proposal scoring components** Does an Appendix E, F, G need to be completed for each State Fiscal Year? If so, do we include SFY 21 for the current budget we are working under, or for SFY 22 - 24 and projecting the figures?	No. See Addendum #6, revised Appendix E – Budget Template for Startup Costs, and revised Appendix F – Rate Setting Form. Appendix G – Staff Form is no longer being required for the RFP.
17.	**Section 3.4.2 Cost proposal scoring components** a) Should a proposer include expenses in the proposed budgets for 6 months of aftercare as required in Section 2.2.3.15? B) Or Is aftercare an activity and expense of the CME?	a) Yes. If there are Start-up Costs associated this activity then the Vendor should include this in the revised Appendix E – Budget for Start-up Costs. Any ongoing, operational expenses for this activity should be included in the revised Appendix F – Rate Setting Form. b) Aftercare is a required service for the residential treatment Vendor. The Department plans to have the CME provide Enhanced Care Coordination for most cases.
18.	**Section 3.4.2 Cost proposal scoring components** a) Should a proposer include expenses in the proposed budgets for Evidence Based Practices (EBP)/best practice training? b) Or will this be paid by Granite State?	a) Yes. See Addendum #6. The program technical proposal and corresponding cost proposal should include the cost for initial and ongoing training and implementation of the EBP including fidelity measures. b) GSC and other training partners offer various trainings, but would not offer all of what a program would need.

No.	Question	Answer
19.	**Section 3.4.2 Cost proposal scoring components** a) How does a proposer delineate startup cost vs operations costs such as for accreditation plans, handicap ramp? b) What practices can a Proposer use to estimate costs?	a) See Addendum #6. b) See Appendix F2 – Rate Setting Form Instructions.
20.	**RFP Section 3.4.2 Cost proposal scoring components** Do we, in essence, need to submit four separate Rate-Setting Forms and Program staff lists, one each for the periods: May 1, 2021-June 30, 2021 July 1, 2021-June 30, 2022 July 1, 2022-June 30, 2023 July 1, 2023-June 30, 2024	No. See Addendum #6.
21.	**Section 3.4.2 Cost proposal scoring components and Section 7.4 Cost Proposal Contents** **a**) If a Vendor is a current residential treatment provider and not starting up a new program, does that mean Appendix E is not necessary to submit in our proposal? b) Should Appendix F-Rate Setting Form be completed for the entire contract period or annualized? c) Where in the RFP are the requirements for a Budget narrative?	a) See Addendum #6. Current Vendors of residential treatment services and potential new Vendors may request startup costs as defined in the RFP. Proposers must use revised Appendix E to propose the startup costs. b) See Addendum #6 and revised Appendix F Rate Setting Form, which must include operating expenses for an annual basis (one, 12-month period). c) See Addendum #6.
22.	**Section : 4. Finance** If the contract is awarded for three years, does it mean that the rates will be established for three years, with no possibility of an increase?	See Addendum #6.

No.	Question	Answer
23.	**Section 4.1 Finance Standards** a) Does an agency need to be able to accept private insurance? b) If yes to letter a), then what is the process? c) Will the private insurance pay the rate that is going to be established in the contract with the State or will the private insurance set new rates with each agency?	a) It is highly encouraged for Vendors to accept private insurance. The Department is moving in a direction where children accessing residential treatment will need to meet medical necessity. In addition, Vendors will need to accept children who are enrolled with the Department's contracted Medicaid Managed Care Organization (MCO). b) Vendors are responsible for enrolling with private insurance carriers and MCOs. c) Private insurance carriers set their own rates with Vendors.
24.	**Section 4.1 Financial Standards** How will residential treatment services be billed to Medicaid?	Yes. Currently residential treatment is billed as a fee for service under Medicaid and not part of the Department's Medicaid Managed Care Organization (MCO) program. The Department is actively working on shifting residential treatment services to become a benefit, which is paid for under the Medicaid MCO program.
25.	**Section 4.2 Description of payment structure** If the contract is awarded for three years, does it mean that the rates will be established for three years, with no possibility of an increase?	The rate will be set for the term of the contract. See Addendum #6. Rates may be reviewed every two years to follow the State's biennium to consider rate adjustments.
26.	**Section 4.2 Description of payment structure** a) Will rates include an occupancy rate? B) Will monthly payments be consistent or on a bed by bed basis?	a) Yes. See the Appendix F – Rate Setting Form. b) Payments will be based on children, youth, and young adults being served. See Addendum #6.
27.	**Section 4.2 Description of payment structure and Appendix F Rate Setting Form** Whereas MA providers do not establish their own rates of services, and they are instead established through rate setting entities: Operational Services Division (OSD), and any ancillary services are established and regulated in 101 CMR 413.00. Would evidence of these established rates be sufficient to meet the requirements of 9.6 (Appendix F) Rate Setting Form?	No. Out of State Vendors, proposing services must complete the Appendix F – Rate Setting Form.
28.	**Section 7.1 Presentation and Identification and Appendix J** Do we need to complete a technical and cost proposal for each level of care?	Yes. See Addendum #6, and revised Appendix J.

No.	Question	Answer
29.	**Section 7.1 Presentation and Identification and Appendix J** Do we need to complete a technical and cost proposal for each site?	It depends. See Addendum #6, and revised Appendix J Summary of Vendor's Proposed Levels of Care. If there is one program/level of care with multiple physical locations, only one technical and cost proposal are needed. The Proposer must clearly explain how programming and staffing will operate and why the vendor is using this approach, in the revised Appendix D – Technical Proposal Response Template.
30.	**Section 7.1 Presentation and Identification and Appendix J** Of each section in 7.1.1.3 do we need to submit?	See Addendum # 6.
31.	**Section 7.1 Presentation and Identification and Appendix J** If a vendor will be providing the same level of care/residential treatment service to the same population at different sites/locations, would each site require a separate cost and technical proposal?	See Addendum #6, and revised Appendix J Summary of Vendor's Proposed Levels of Care. If the Vendor has multiple programs at one level of care, they must submit multiple proposals. If the Vendor has one program with multiple physical locations, then the Proposer would need to submit one proposal.
32.	**Appendix D - Technical Proposal Template** How can I add information into the template regarding accreditation because there seems to be no place for typing that in on page one?	Yes. See Addendum #6 and revised Appendix D – Technical Proposal Response Template.
33.	**Appendix D Technical Proposal Response Template and Appendix J Summary of Vendors Proposed Levels of Care** Will the template available be updated so that proposers can type in each section being asked? Appendix D and Appendix J, specifically.	Yes. See Addendum #6, revised Appendix D – Technical Proposal Response Template and revised Appendix J Summary of Vendor's Proposed Levels of Care.
34.	**Appendix F - Rate Setting Form** The formulas do not work, line 601 in workbook Staff List.	See Addendum #6 and revised Appendix F – Rate Setting Form. Line 601 is a manual calculation to be completed by the Vendor. The Department fixed the formula on Tab 2142B.
35.	**Appendix F - Rate Setting Form** How do the sums calculate on the 2141 tab/sheet?	See revised Appendix F. The Department corrected the formula on tab 2141B. The sums on tab 2141 sum correctly.

No.	Question	Answer
36.	**Appendix F – Rate Setting Form** What do you want us to do when the formulas do not allow us to add rows in STAFF LIST Form and the WORKBOOK staff list does not compute a final salary for line item 601?	See answer to #34. The Appendix G – Program Staff List is not being required for this RFP, see Addendum #6.
37.	**Appendix H** Do sleep in staff count toward the new awake overnight ratio of 1:8 or do we have to have two awake staff in each of our houses in addition to our sleep in staff?	According to Appendix H – Levels of Care Framework, Staffing Requirements, it reads, : "*Through the contracting process ratios may vary based unique population and programs based on quality treatment and safety." The ratio will depend on the uniqueness of the residential treatment program. A Vendor may provide a program with ratios that may vary from those outlined in Appendix H – Levels of Care Framework based upon unique circumstances of a Vendor's program. Vendors must explain their staffing ratios and the unique circumstances included in their program to justify for the proposed staffing ratio in the revised Appendix D – Technical Proposal Response Template.
38.	**Appendix H** Would you please clarify how Community Based Acute Treatment (CBAT) programs will look? There are standards set forth in Massachusetts but none that we can see in New Hampshire.	See Appendix H, level of Care framework. The Department will be developing standards and anticipates developing standards that may look like that of Massachusetts.
39.	**Appendix I** Appendix I references RFP Section 5.11 Contract Monitoring Provisions and Section 5.12 Statement of Vendors Financial Condition. Where are these sections in the RFP?	These are incorrect references. See Addendum #6 and revised Appendix I for the correct references.

No.	Question	Answer
40.	**Appendix J - Summary of Vendors Proposed Levels of Care** a) Does a vendor need to submit a technical proposal and cost proposal (budgets) by diagnosis? b) If no to letter a), then does a Vendor submit a proposal for each program that contains the diagnosis? c) How many technical and cost proposals do we need to submit? Here is an example: If a Vendor has 3 programs within Level of Care 4 such as Enhanced Residential, CBAT, and ICBAT and in each we treat multiple diagnosis and needs such as problem sexual behavior, highly aggressive behavior, fire setting.	a) No. See Addendum #6 and revised Appendix J Summary of Vendor's Proposed Levels of Care. b) Yes for each program. See Addendum #6 and revised Appendix J Summary of Vendor's Proposed Levels of Care. c) According to this example, the Proposer would need to submit 3 technical proposals with their corresponding cost proposals. See Appendix #6 and revised Appendix J Summary of Vendor's Proposed Levels of Care.
41.	**Section 7.1 Presentation and Identification and Appendix J - Summary of Vendors Proposed Levels of Care** a) How would I submit a proposal for two different levels of care with 16-shared beds? b) Would this include two separate budgets? c) Would this include rates for 16 beds?	a) See Answer to #1. See Addendum #6, and revised Appendix J Summary of Vendor's Proposed Levels of Care. b) Yes. See Addendum #6 and revised Appendix J Summary of Vendor's Proposed Levels of Care. c) Yes. Complete a cost proposal for each program/level of care, for 16 beds per program. Vendor must clearly indicate that the beds are shared in their Appendix D Technical Proposal Response Template and the Cost proposal.